Annual Provider Training 2020 Amerigroup Iowa, Inc. (Amerigroup) Question and Answers

This document is a collection of answers to questions received in the chat during the IME's Annual Provider Training session held in November of 2020. Amerigroup has provided answers to questions directed towards their team. The questions as asked are preserved in black text, and Amerigroup's answers are provided in blue text.

1) From Sue Miller: Yes, you must send supplemental each time, because provider information continues on the supplemental PA form. AMG is requiring physician information including the doctors TIN that providers do not have. Any Advice?
    a. Because providers can work under multiple hospital systems and physician groups, having the Tax Identification Number (TIN) is a requirement when submitting a prior authorization request.

2) From Sherri Hopper: We have a lot of issues with Amerigroup processing secondary when the primary is a Medicare Advantage plan.
    a. Amerigroup has recently issued a provider bulletin available on our website that spells out the change Amerigroup made to remove a prior authorization requirement for Medicare claims. The EOB is still required for submission with the claim to show payment from the primary payer.

3) From Jessica: Lisa Welter I got a letter stating the same thing. We always billed the XB condition code along with XB Not Homebound in the remarks field to indicate the patient does not meet Medicare criteria. Now we are getting recoupment notices from Amerigroup saying they are taking money back. What changed? What am I doing wrong?
    a. Please refer to the Provider Bulletin "Non-covered home health claims submission" on our website providers.amerigroup.com/IA. If you still have questions, please reach out to your provider representative.

4) From sschneider: Will Amerigroup be making changes to improve the response to prior authorizations? Waiting for responses for 2-3 weeks poses issues in treatment of patients.
    a. Amerigroup processes authorization within the stated periods. If you have examples of PA requests that not being reviewed, please reach out to your provider rep who will help in working with the UM department.

5) From agnesh : For Availity you can add up to 4 claims with the same issue either for the same patient or other patients and I get notice the denial was overturned however Amerigroup is only processing the first claim on the appeal and nothing on the other claims attached. When will this be fixed? Since Availity training says to submit multiples of same issue on one appeal. From Genevieve: Yes Agnesh, we have experienced this as well. We receive no notification for other claims included in an appeal, only the first submission.
    a. Amerigroup has been working closely with the claims/appeal review team to provide additional education for the review of submitted spreadsheets. The reviewer's desktop instructions highlight the need to process all claims submitted by providers. If you are still experiencing issues, please reach out to your rep who will escalate the issue for you.

6) From User: Amerigroup is not recognizing the 59 modifier on our therapy claims. We constantly have to appeal these incorrect denials. Are they working on correcting this issue? From mldyer: we have experienced the same problem and when you file a dispute, we get duplicate claim denials From cfredericks: We are experiencing the same issue w/the 59 modifier on PT claims. Would also like to know the answer to this question. Thank you. From matheasonaj: What we have experienced is 59 Mod claims- hits and edit for Amerigroup. We have to submit reconsiderations with chart documentation on tons of claims that we bill with the 59.. No way around it. From Sherri Hopper: We have issues with 59 and 25 modifiers, Avastin for the eyes and all flu vaccines with Amerigroup. From smitcarm : I have been having issues with flu vaccines, too
    a. Please refer to the Provider Bulletin "Non-covered home health claims submission" on our website providers.amerigroup.com/IA. If this does not answer your questions completely, please reach out to your provider representative.
    b. For Avastin and flu vaccine issues, please reach out to your provider representative with additional information.

7) From JMayland: How do we bill COVID days to Amerigroup so they will pay correctly? COVID days at a $300 increase and then the balance of the days at regular Medicaid rate. DR in the condition code is making AG pay all days at the increase COVID rate. From Erica DeGroot: The problem I have is I was told to bill as an inpatient service but it is an outpatient service so I get denials constantly.
    a. The below is for Nursing facilities –but applies to hospice as well. Providers need to bill one claim line for days w/COVID and the add-on and another line for days without add on – (or 3 claim lines if it falls in the middle)
    Example:
    12/1-12/21 – 21 days X NF per diem rate (normal billing practices)
    12/22 -12/31 – 10 x NF per diem rate + $3000 ($300 x10)
    The DR (disaster related) condition code is recognized at the claim level. AGP claims set up will allow the additional payment to pay up to *billed charges*. Therefore, the providers could bill the respective additional $300 per diem x days where CRR (COVID Relief Rate) was provided. If a provider so wishes and NOT required-a claims note submitted in the Remarks Box/Field 80 on the UB-04 would also help identify the amount of days billed for CRR, if not every day otherwise submitted on the claim would be subject to the additional payment.
    Please keep in mind, if you only bill the per-diem rate (and do not increase the charges) for the CRR, then we will not reimburse. We only can reimburse up to what is billed.

8) From sschneider: We have issues with Amerigroup being the secondary insurance and authorizing a substantially lower number of visits for PT then the primary insurance. What is the best way to get the auth. to be more in tune with the primary insurance?
    a. The claims team will need to look at examples of the claims being brought forth on this issue. Please reach out to your rep for further assistance.

9) From Sarah Adams: How does a provider document or how does Amerigroup notice the issues coming through. What makes something significant enough to make it on this list? What is your procedure?
    a. Amerigroup gathers data from the appeals submitted via Availity and analyzes to identify trends in claim denials. From there the issue is reviewed and if a system correction is needed, the project will be added to our notification on the website.

10) From User: For Amerigroup, the maximum of 12 visits for all physical therapy requests is unreasonable, especially in post-surgery situations. Cases should be looked at individually.
    a. Cases are reviewed individually per the diagnosis codes so someone that has a knee replacement will not have PT visits from a hip replacement tied together. For further explanation, please reach out to your provider representative.

11) From Sue Miller: Is the Amerigroup EVV training different from the Carebridge training? Where is the link for the Amerigroup training?
    a. Link for EVV and Carebridge training is available on our public website. Providers.amerigroup.com/IA

12) From Genevieve: I agree with User, we are consistently reduced with our authorizations and are told that adults have max 12 visits per request. This is not reasonable for post-surgical and those with multiple co-morbidities. It seems like since the beginning of the year auth reductions and denials have increased 100% this does not make sense if healthcare providers are trying to reduce surgical procedures and dependence on opioid drugs. Amerigroup should include more factors in the algorithm that they are using.
    a. This suggestion will be taken back to our UM team for review and possible inclusion on future policies.

13) From agnesh : What is Amerigroup doing to process claims for someone who has no insurance when they go inpatient and Iowa Medicaid gives them retro coverage to cover the inpatient days. You cannot get an authorization after the person has left the hospital and we are not notified they have Amerigroup for even a month later. Amerigroup denies for no authorization requested at time. We have been working with our provider rep however; I have some back to June 2019 that have not paid.
    a. The processing instructions for the claims reviewers were recently updated to include the steps for presumptive and retro eligible members. Please make sure to include any notice the member may have supplied in the appeal to get these claims past the PA requirement.

14) From maysn: For Providers Reps for Amerigroup - If our provider rep is not calling or returning emails or phone calls. within 2weeks sometimes longer, Who can we contact for assistance
    a. Managers for the representatives are shown on the territory maps on the public website. Providers.amerigroup.com/IA

15) From tanderson: Receiving Amerigroup recoupment letters for claims in 2017/2018 stating the State disenrolled member from MCO. Claims should have gone to IME. How are we to get payment for these old claims when at time of service it clearly stated they had Amerigroup?
    a. If Amerigroup receives notification from Iowa Medicaid that member eligibility has changed, Amerigroup is required to recoup the claim payment. The claim should be submitted per directions on the letter received.

16) How do I find out who my provider relations rep is for Amerigroup?
    a. Territory maps are shown on the public website. Providers.amerigroup.com/IA

17) From Joseph Brecht: Why does Amerigroup require two appeals before the issue can be escalated to the provider rep?
    a. Submission via the Availity portal allows the claims review team to identify systematic issues and work to correct those errors. Our corporate teams have more knowledge then PSO teams in the appropriate claims processing and handling.

18) Tanderson: agreed Erica. How can 13 ITC provider reps for the state take care of all of these issues?
    a. This is a question for ITC.

19) From mldyer : in submitting a dispute on Availity and the response given to the dispute is vague or not correct and we try to respond to that dispute, we are getting a generic response that it is a duplicate request? Is there a way around this? I do not feel our claims are actually being looked at and it appears they are just being "scrubbed" and we are given a generic answer.
    a. Please all the Provider Services phone number directly and speak to a phone rep directly. They will be able to help explain the issue that caused the claim denial. Phone number is 1-800-454-3730.

20) From Sue Miller: the universal PA forms are not being used by the MCO's as explained in the presentation. You must submit the supplemental form withal PA requests as it has additional provider information on the supplemental form. Additionally the MCO's UM teams are requesting physician information and there is not a clear field on the universal PA form and providers do not have access to the physician's TIN only their own. These are HH PA and we need to have either provider training, or MCO UM training. AMG returns the PA if we do not use the physician as the requesting provider, this is not how we were ever trained to submit PA. Requesting provider and servicing provider are usually the same, but AMG does not recognize the check box on the Universal PA form and says requesting provider is the physician. Much confusion, mostly it seems on the MCO's side it seems on the universal PA form completion.
    a. Amerigroup does recognize and use the universal PA form developed in conjunction with IME and ITC.

21) From Mindy Oxenford: We are having issues with reimbursement regarding use of the 59 modifier with the NCCI edits. We have been told by both ITC and Amerigroup that it is a problem but have noticed that it is not on the list of known system configuration issues to be fixed and we continue to see denials. Is anyone else having this problem? MCO's--how can we efficiently get this fixed? yes, it is an issue, we have many bundling denials for 59 and X modifiers for therapy claims
    a. Additional information is needed on this question. Please reach out directly to your provider representative for assistance.

22) From Bobbie Wulf, Washington and Louisa County CDS : If someone is on an HCBS Waiting List but is a Medicaid recipient what case management service within the MCO is utilized to coordinate any other services that the member may need? From Kristine: We have 59 and XS (which one should we be using for Iowa Total Care and Amerigroup?) issues with GI procedures.
    a. Additional information is needed on this question. Please reach out directly to your provider representative for assistance.

23) From Dena Knapp: Amerigroup.... I am an IA CDAC Provider w/client using HCBS. I would love being able to view online current and past remittances. How do I go about doing that? Also, how can I go about getting direct deposit?
    a. Please call CAQH at 1-844-815-9763 if you have questions about direct deposit and inform them you are a CDAC provider.
    b. For viewing current and past remittances, please reach out to your provider representative at AmerigroupPSO@amerigroup.com who can help you with viewing remittances.

24) Joilen: We also are getting recoupments for other insurance, dating back several years. The 'primary' insurance will not pay the claims as past timely filing. I am not sure if this is ITC or Amerigroup.
    a. If the member has an active primary policy, it is a state requirement that the policy pays for the claim prior to a Medicaid payment.

25) From Dena Knapp: Amerigroup... I am an Independent IA CDAC Provider through HCBS waiver assigned a 9-digit NPI # back in 2008 starting with X000... I find AmeriGroup, Availity, and EDISS all are asking me for a 10-digit NPI number. What can I do or use to help me identify who I am more easily with the Amerigroup system Representatives?
    a. The 9-digit NPI issued by the state that starts with an X is the NPI Amerigroup and Availity is requesting.

26) From Joyce Vonk: Does IME realize the administrative time and cost involved with these modifier denials by Amerigroup and ITC for claims that are coded correctly?
    a. Amerigroup is working to correct issues being identified by providers. Please reach out to representative with specific issues.

27) 11:12:01 From Dawn Logan : The constant request for repayment of claims because someone has Medicare is ridiculous
28) 11:12:07 From Dawn Logan : With Amerigroup
    a. Will need additional information to answer these questions. Please reach out to your provider representative with additional information.

29) 11:12:10 From tkastli : We do the appeal and it still gets taken back
30) 11:12:11 From Jennifer Pavlovec: Renae - yes! Man, units vs. visits with Amerigroup is a pain and has been since day one.
31) 11:12:18 From tsommers : Amerigroup we don't have time to keep appealing incorrect
32) 11:12:40 From Mary Hermanson: I agree.
33) From Dawn Logan : It would be beneficial if Amerigroup could fix the ongoing issue with the dual eligible clients - I spend so much time appealing incorrect recoupment requests and claims denied in error.
    a. Will need additional information to answer these questions. Please reach out to your provider representative with additional information.

34) 11:13:25 From tsommers : Can't emphasize enough the amount of wasted time for Amerigroup cost-containment refund requests
35) 11:13:35 From Alyssa Luckstead : Agree
36) 11:13:40 From Jennifer Pavlovec: So Julie, apparently there is no interest in training cost containment at Amerigroup and instead just placing the burden on the providers? Very disappointing to hear... Delaying payment and increased administrative burden on the providers shouldn't be the answer to so many issues that providers have with Amerigroup
    a. Amerigroup's cost containment department continues to education associates on the appropriate review of claims to match Iowa requirements. If you have additional issues, please reach out to your representative for more help.

37) 11:14:00 from tsommers: AGREE!
38) 11:14:23 From Deanna Beyerink: Agree!
39) 11:14:56 From tkastli : Please Please take care of Cost containment tkastli@clarkpo.com
40) 11:15:03 From Kasi Wares: so won't address these issues on the call?
41) 11:15:46 From Roxanne.Wolverton: I had the box numbers backwards. My apologies. For Amerigroup.
42) 11:16:00 From Michael Kitzman: Kasi Wares, can you be more specific as to what issues you are concerned about?

43) From Jodi: What is the best way to submit a claim when IA Medicaid/Amerigroup/Iowa Total care is the tertiary coverage? Need to be able to submit multiple eobs.
    a. Amerigroup accepts multiple pages of attachments. OHI payments on the claim form should include all payments from other health insurance policies.

44) From AF01354 : Regarding pharmacy questions for Amerigroup:
    a. The pharmacy would start by contacting IngenioRx (CVS) https://www.caremark.com/wps/portal/FOR_HEALTH_PROS_HOME for reimbursement issues. We follow the State pricing.

45) From Roxanne.Wolverton : Amerigroup still denies claims requesting primary EOB's
    a. Will need additional information to answer these questions. Please reach out to your provider representative with additional information.

46) From John Huber: Kaela-Mae who do we contact for escalation of denied same day service claim projects?
    a. This question is for ITC.

47) Ashley May: EOBs are not required for room and board! but we keep getting claim denials
    a. Will need additional information to answer these questions. Please reach out to your provider representative with additional information.

48) From DebKotcher: So both AMG and ITC would prefer the Facility (SNF) NPI in box 77?
    a. Amerigroup recently published a provider bulletin for the box 77 directions. It is available on the public website. Provider.amerigroup.com/IA

49) From Roxanne.Wolverton: Why does Amerigroup pay Hospice claims at incorrect rates, constantly? This is my biggest denial from Amerigroup.
    a. Amerigroup was having issues with correct rates for Hospice claims. That correction project was recently completed.

50) From seibertl: I am sorry the answer from ITC and Amerigroup is incorrect. Medicare does not cover R&B
    a. Please submit claims to your provider representation for clarification on this issue.

51) From Jodi : In regards to the tertiary submission - the Medicaid and MCO's do not accept paper - want to know the best processing steps to get the tertiary claim and eobs to a Medicaid processor to have adjudicated
    a. Amerigroup accepts multiple pages of attachments. OHI payments on the claim form should include all payments from other health insurance policies.

52) From seibertl : Can customer service receive this information stating no eob is required
53) From John Huber: Amerigroup Behavioral health Provider representative contact information please? jhuber@bethany-gc.org
    a. Our representative territory maps are available on the website at providers.amerigroup.com/IA. Since is do not know your location, we will need to refer to the map.
    b. https://providers.amerigroup.com/IA/Pages/ia.aspx MAPS for our PR reps and managers are on our website.

54) From Shasta: I have left voicemails for my provider rep and her supervisor at AG and have not received responses, who would be my next point of contact?
    a. Please reach out to the representative's manager. https://providers.amerigroup.com/IA/Pages/ia.aspx MAPS for our PR reps and managers are on our website.

55) 11:39:42 From AE00501: aimee.underwood@amerigroup.com is correct on the map. From John Huber: So whom do we contact if Aimee is not responding to us? jhuber@bethany-qc.org
    a. From AE00501: This is Aimee; I will touch base with you after this. Julie is also my manager and you can cc her on emails. Thanks!

56) 11:41:33 From Kayla Beck: Can the way our physicians are listed be streamlined in Availty?
    a. Will need additional information to answer these questions. Please reach out to your provider representative with additional information.

57) 11:42:28 From tkastli : NOPE
58) 11:43:13 From tkastli : Traci Kastli I have done reconsiderations and resubmitted and they have just been Voided and I get nothing
    a. Will need additional information to answer these questions. Please reach out to your provider representative with additional information.

59) How do we determine who our provider rep is since were out of state
    a. Contiguous states are shown on the provider map with the identified representative. You could also reach out to one of the managers identified for help.

60) Amerigroup Question: Will the Availity portal be able to update claims that have been previously paid or denied like the ITC portal allows us to do?
    a. Amerigroup will take this suggestion back to Availity to see if possible.

61) AGP/ITC: Can a better policy be implemented for the on-going issue of presumptive eligibility and claims denied by the MCO's for no notification/authorization because coverage was made retroactive with an MCO after the discharge date? Services are being provided but reimbursement is being withheld. We have seen the same issue as Michelle O'Meara. Numerous claims from 2019 that have already been paid are being paid again. Will all Ca AA denials be reprocessed for payments?
    a. The processing instructions for the claims reviewers was recently updated to include the steps for presumptive and retro eligible members. Please make sure to include any notice the member may have supplied in the appeal to get these claims past the PA requirement.

62) AGP/ITC: We experience the same issues with retro-authorization requests as Monique...many times our clients (Residential Treatment Facility) come in with inactive or no Medicaid status, due to a court ordered placement. Both MCO's seem to not understand that this is happening on a regular basis and that the provider does not have any control. We are required to provide the services (that do NOT require a pre-authorization by IME) but struggle to get back-dated authorizations for those services (BHIS),
    a. The processing instructions for the claims reviewers was recently updated to include the steps for presumptive and retro eligible members. Please make sure to include any notice the member may have supplied in the appeal to get these claims past the PA requirement.

63) AGP: We have an issue with hearing back from our provider reps for Amerigroup and Iowa Total Care. We have many "projects" that have been started and then we do not hear from them for months it seems. After attempts to contact them it is rare that we hear back. I should say for unpaid home delivered meal claims.
    a. Please reach out to the manager identified on the territory map for the reps, available on our public website.

64) AGP: Is there a certain code that should be on the claims for Residential Care Facility vs ICF when billing Amerigroup as they are paying our claim for RCF at the rate of ICF?
    a. Please reach out to your rep to confirm that rates are correct in the system. We have recently update a large group of rates and should have claims sweeps completed soon.

65) Amerigroup... I am an IA CDAC Provider with a client using HCBS. I would love being able to view online current and past TMC remittances. How do I go about doing that? In addition, how can I go about getting direct payment?
    a. You are able to sign up for EFT and the process is shown on the public website at providers.amerigroup.com/IA.

66) Amerigroup: When we request prior authorization for PT/OT to Amerigroup, it gives us the option to request units or visits and we always request visits and get an authorization, for example of 12 visits, but when claims process, it counts the 12 as units - units and visits are not the same. We may bill anywhere from two units to four units per visit. How can we get the authorization and claims on the same page? I have spent hours on the phone asking about claims denied due to authorization when we had the visits, but claims only sees a # so it sounds like authorization is not entering the correct correlated units of 12 visits x 4 units.
    a. Amerigroup uses units as the appropriate measure.

67) – AGP/ITC When we can't obtain clarification and our provider reps do not respond, will the 30-day timely filing for appeals be waived?
    a. Will need additional information to answer these questions. Please reach out to your provider representative with additional information. If you are having issues making connection with your representative, please reach out to the manager shown on the territory map.